Clinical Protocol for the Early Detection of Cervical Cancer  
May 2013

This Clinical Protocol is based upon screening guidelines developed by the American Cancer Society, the US Preventative Services Task Force, and the American Society for Clinical Pathology (2012), and endorses the use of the American Society for Colposcopy and Cervical Pathology’s (ASCCP) 2012 Updated Consensus Guidelines for Managing Abnormal Cervical Cancer Screening Tests and Cancer Precursors. Guidelines are referenced in this document and may be found at [http://www.asccp.org/](http://www.asccp.org/)

Screening Tests
Testing for cervical cancer is performed using either Liquid-Based Cytology or Conventional (slide) Pap Test. Consideration should be given to the use of HR-HPV (High-Risk Human Papillomavirus) testing in conjunction with cervical cytology for screening women 30 years of age and older.

Age to Initiate Screening:
Cervical cancer screening should begin at age 21 years. Women aged younger than 21 should not be screened regardless of the age of sexual initiation or other risk factors.

General Information
• The need for cervical cancer screening should not be the only basis for the onset of gynecological care.
• Adolescents must be able to obtain appropriate preventative health care, including, but not limited to, an assessment of health risks, counseling for pregnancy and sexually transmitted disease (STD) prevention, provision of contraception methods, and treatment of STD’s; even if they do not need a Pap test.
• Clinical breast exam and yearly speculum and bimanual pelvic examinations should be provided even if no cervical cancer screening is performed.
• For the purpose of these guidelines an ADOLESCENT is defined as 20 years of age or younger.
• Adolescents and young women who have received the HPV vaccine should continue cervical cancer screening according to the current guidelines.
• In the absence of endocervical cells, if a Pap smear is satisfactory and negative, then regular screening should be continued.

<table>
<thead>
<tr>
<th>Age to Begin</th>
<th>Screening Exam</th>
<th>Screening Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 21 - 29</td>
<td>Conventional Pap Test OR Liquid Based Cytology (LBC)</td>
<td>Pap test only every 3 years</td>
</tr>
<tr>
<td>Age 30 - 65</td>
<td>HPV and cytology “cotesting” (preferred)</td>
<td>Every 5 years</td>
</tr>
<tr>
<td>Age 30 - 65</td>
<td>Conventional Pap Test OR Liquid Based Cytology (LBC) (acceptable)</td>
<td>Pap test alone every 3 years</td>
</tr>
</tbody>
</table>

Frequency of Screening:
HR-HPV as an adjunct to cervical cytology testing may be used for cervical cancer screening in women 30 years of age or older. If both tests are negative, testing occurs every five years. For abnormal results, follow-up guidelines may be found on [http://www.asccp.org/](http://www.asccp.org/).
Special Considerations:

- Women with a histologically-confirmed HSIL (colposcopy results of \( \geq \) CIN2), whether or not they receive treatment - continue cervical cancer screening on a regular basis, for 20 years.
- Screening for cervical cancer past age 65 may be indicated. Regular screening is Pap testing every three years, or Pap/HPV co-testing every 5 years.
- Changes in cervical screening guidelines (2012) are for the general population and do not address women who are immunocompromised (e.g., infection with the human immunodeficiency virus).
  - Once HIV is diagnosed, Pap screening should be begin for females who have initiated sexual activity regardless of age or at age 21 for women who have not initiated sexual activity.
  - The Pap test should be obtained twice during the first year after diagnosis of HIV infection.
  - After determining that baseline cervical screening results show no atypical cells or neoplasia, the Pap test should be repeated annually.
  - There are no data to support the use of HPV-testing for HIV-seropositive women \( \geq 30 \) years to increase or decrease the frequency of Pap tests from 1 year intervals for women with normal cervical cytology.
  - Published data are insufficient to support use of HPV DNA testing in triage of ASC-US among HIV-seropositive women resulting in a recommendation to perform colposcopy for HIV-seropositive women with ASC-US.
  - Routine screening of HIV-seropositive women with vaginal cytology after hysterectomy for benign disease is not recommended.
  - An upper age limit on Pap cervical screening has not been established for HIV-seropositive women.
  - For follow-up, immunosuppressed women with abnormal cytology results should be managed in the same way as immunocompetent women.
- Women who had in utero DES exposure – continue ANNUAL cervical cancer screening (Pap test only) regardless of the testing method.
- For women whose cytology exam is satisfactory but obscured or partially obscured by inflammation – repeat the exam in 6 months. Refer for colposcopy if subsequent cytology is still interpreted as obscured, partially obscured or otherwise abnormal.
- Women whose cytology exam is unsatisfactory need a repeat cytology exam within the next 2 to 4 months.
- Per the ASCCP guidelines (follow-up of abnormal Pap test results) adolescents and pregnant women are also given special consideration. See guidelines for details at [http://www.asccp.org/](http://www.asccp.org/).
- Endocervical curettage is unacceptable in pregnant women
- Colposcopy may be deferred until the postpartum examination
- During pregnancy, invasive cervical cancer is the only indication for treatment
- Guidelines for women aged 21-24 years can be extrapolated to adolescents inadvertently screened.

For Women Who Have Had a Hysterecotomy:
• Hysterectomy for INVASIVE cervical cancer -- continue ANNUAL Pap testing.
• For women who still have a cervix, continue testing as indicated by age and Pap history.
• Total hysterectomy for benign gynecological disease (no cervix present) - screening with vaginal cytology is NOT indicated; this does not preclude a pelvic exam.

Upper Age Limit for Screening: Women aged older than 65 years with evidence of adequate negative prior screening and no history of CIN2+ within the last 20 years should not be screened for cervical cancer with any modality (adequate negative prior screening is defined as 3 consecutive negative cytology results or 2 consecutive negative cotests within the 10 years before ceasing screening, with the most recent test occurring within the past 5 years). A Pap test or Pap/HPV co-test is encouraged if no adequate history can be documented.

Once screening is discontinued, it should not be started for any reason, even if a woman reports having a new sexual partner.

Indications for Referral to a Qualified Colposcopist:
• Women age 25 and under requiring colposcopy services
• Pregnant women with HSIL cytology.
• Women with a significant cervical lesion in which “see and treat” may be indicated
• Women desiring fertility who, after excisional treatment, have recurrent or persistent cervical dysplasia
• Women who have had two “unsatisfactory for evaluation” tests 2-4 months apart
• Women with AGC (Atypical Glandular Cells) or AIS (Adenocarcinoma in situ) on cytology. Management follows the algorithm found at http://www.asccp.org/.
• Women with any gynecologic cancer should be referred to a Gynecologic Oncologist.

Follow-up of Abnormal Cytology Results:
The website http://www.asccp.org/ contains algorithms on the follow-up of:
• Unsatisfactory Cytology
• Cytology NILM but EC/TX Absent/Insufficient
• Management of Women ≥ Age 30, who are Cytology Negative, but HPV Positive
• Management of Women with Atypical Squamous Cells of Undetermined Significance (ASC-US) on Cytology
• Management of Women Ages 21-24 years with either Atypical Cells of Undetermined Significance (ASC-US) or Low-grade Squamous Intraepithelial Lesion (LSIL)
• Management of Women with Low-grade Squamous Intraepithelial Lesion (LSIL)
• Management of Pregnant Women with Low-grade Squamous Intraepithelial Lesion (LSIL)
• Management of Women with Atypical Squamous Cells: Cannot Exclude High-grade SIL (ASC-H)
• Management of Women Ages 21-24 years with Atypical Squamous Cells: Cannot Exclude High-grade SIL (ASC-H) and High-grade Squamous Intraepithelial Lesion (HSIL)
• Management of Women with High-grade Squamous Intraepithelial Lesion (HSIL)
• Initial Work-up of Women with Atypical Glandular Cells (AGC)
• Subsequent Management of Women with Atypical Glandular Cells (AGC)
• Management of Women with No Lesion or Biopsy-confirmed Cervical Intraepithelial Neoplasia – Grade 1 (CIN1) Preceded by “Lesser Abnormalities”
• Management of Women with No Lesion or Biopsy-confirmed Cervical Intraepithelial Neoplasia – Grade 1 (CIN1) Preceded by ASC-H or HSIL Cytology
• Management of Women Ages 21-24 with No Lesion or Biopsy-confirmed Cervical
Intraepithelial Lesion – Grade 1 (CIN1)

- Management of Women with Biopsy-confirmed Cervical Intraepithelial Neoplasia – Grade 2 and 3 (CIN2,3)
- Management of Young Women with Biopsy-confirmed Cervical Intraepithelial Neoplasia – Grade 2 and 3 (CIN2,3) in Special Circumstances
- Management of Women Diagnosed with Adenocarcinoma in-situ (AIS) during a Diagnostic Excisional Procedure
- Interim Guidance for Managing Reports using the Lower Anogenital Squamous Terminology (LAST) Histopathology Diagnoses

A diagnostic excisional procedure is recommended for women with HSIL and an unsatisfactory colposcopy, except when pregnant.
A diagnostic excisional procedure is recommended for adolescents and young women with HSIL when CIN of any grade is identified on ECC.

A diagnostic excisional procedure is recommended for women age 21-24 years with HSIL when colposcopy is unsatisfactory, or CIN 2, CIN 3, CIN 2, 3 or ungraded CIN is identified on endocervical sampling. Ablation is unacceptable for HSIL cytology if:
- No colposcopy was done
- CIN 2/3 is not identified colposcopically

ECC identifies CIN of any grade when the endocervical assessment identifies CIN2, CIN 3, CIN2, 3 or ungraded CIN.

In women less than 35 years of age with an AGC cytology result, an endometrial biopsy should be performed in the presence of, but is not limited to, the following conditions:
- Dysfunctional uterine bleeding
- At risk for chronic anovulation
- A change in menstrual flow

Reminder and Tracking System: Clinicians and agencies should be encouraged to develop a system which will both remind women to schedule cancer screening testing and notify women of abnormal cervical cancer screening tests (which include positive HPV – High Risk test results), asking them to schedule follow-up diagnostic testing.

Patient Education: Clinicians should educate all women about the components of the pelvic exam, including whether cervical cancer screening is performed and whether or not the woman is being tested for STDs, including HPV. Given the recommended increase in screening interval, consideration should be given to providing women with copies of their Pap test/HPV test results.

- Clinical Protocol for the Early Detection of Cervical Cancer (May 2013) was developed by the Michigan Cancer Consortium’s Cervical Cancer Advisory Committee as a reference for use by health care providers.